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Environmental temperature and growth faltering in African children: a cross-sectional study

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Research in context

Evidence before this study

We searched PubMed between Jan 1, 1900, and Aug 1, 2019 and EMBASE between Jan 1, 1980 and Aug 1, 2019, and identified 45 unique studies with titles containing the terms “temperature*”, “climate” or “heat” combined with “*nutrition”, “stunting”, “wasting”, “human growth”, “child growth”, “growth failure” or “growth faltering”. One modelling study proposed the hypothesis that child growth faltering is linked to high environmental temperatures, *via*: (1) an adaptive response to heat, (2) reduced appetite and (3) the energetic cost of thermoregulation. The study recommended empirical investigation of its hypothesis, but we found no studies that did so. Five studies explored the relationship between environmental temperature and child growth, as mediated by food prices, income and/or agriculture, but none investigated a direct biological effect.

Added value of this study

We conducted a preliminary study to investigate a direct effect of high environmental temperatures on early childhood growth. By analysing data for 656,107 children aged 0-5 years in 29 countries across sub-Saharan Africa (SSA), a region where growth faltering persists, we show that children living in hotter parts of SSA are more likely to be wasted, underweight and concurrently stunted and wasted, but less likely to be stunted, than in cooler areas. Specifically, monthly mean daytime land surface temperatures above 35°C were associated with a 27% increase in the odds of wasting, a 9% increase in the odds of underweight and a 23% increase in concurrent stunting with wasting, but a 10% reduction in stunting, compared to less than 30°C after controlling for prespecified covariables.

Implications of all the available evidence

Child growth faltering remains a major source of morbidity and mortality in SSA despite the scale-up of intensive nutrition, water and sanitation interventions and widespread reductions in diarrhoea and all-cause mortality. To guide effective intervention, the missing causes of growth faltering urgently need to be understood. Our study is one of the first to consider a direct causal relationship between high environmental temperature and child growth faltering. We find evidence in support of this relationship in SSA, with major potential implications for health. Anthropogenic climate change is expected to increase mean annual temperatures by 2°C over Africa by the end of this century, relative to the late 20th century, with some scenarios showing rises of between 3°C and 6°C for the same period. Our study suggests that increasing temperature in SSA may increase the prevalence of wasting, underweight and concurrent stunting and wasting, but decrease the prevalence of stunting. Future studies are needed to validate our findings, to investigate causal pathways, and to find strategies to mitigate against any effects of climate change on child growth.

Abstract

Background: Child growth faltering persists in sub-Saharan Africa (SSA) despite the scale-up of nutrition, water and sanitation interventions. It has been hypothesised that high temperatures may contribute to child growth faltering *via*: (1) an adaptive response to heat, (2) reduced appetite and (3) the energetic cost of thermoregulation. We conducted a cross-sectional study to assess whether child growth faltering is related to environmental temperature in SSA.

Methods: Data were extracted from 52 Demographic and Health Surveys dating from 2003 to 2016 that recorded anthropometric data in children aged 0-5 years and were linked with remotely-sensed monthly mean daytime land surface temperature (LST) for 2000-2016. The odds of stunting (low height-for-age), wasting (low weight-for-height) and underweight (low weight-for-age) relative to LST were determined using multivariable logistic regression.

Findings: The study population comprised 656,107 children resident in 373,012 households. Monthly mean daytime LST above 35°C was associated with a 27% increase in the odds of wasting (Odds Ratio (OR) 1.27, 95% confidence intervals (CI) 1.16-1.38, $p < 0.0001$), a 9% increase in the odds of underweight (OR 1.09, 95% CI 1.02-1.16, $p = 0.0073$) and a 23% increase in concurrent stunting with wasting (OR 1.23, 95% CI 1.07-1.41, $p = 0.0037$), but a 10% reduction in stunting (OR 0.90, 95% CI 0.85-0.96, $p = 0.00047$) compared to less than 30°C.

Interpretation: Children living in hotter parts of SSA are more likely to be wasted, underweight and concurrently stunted and wasted, but less likely to be stunted, than in cooler areas. Studies are needed to further investigate the relationship between temperature and child growth, including whether there is a direct effect not mediated by food security, regional wealth and other environmental variables. Rising temperature, linked to anthropogenic climate change, may increase child growth faltering in SSA.

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Introduction

Childhood undernutrition, including growth faltering and micronutrient deficiencies, is associated with increased mortality and estimated to contribute to ~45% of deaths in young children globally.¹ Despite reductions in stunting, wasting and underweight in nearly all African countries between 2000 and 2015, the prevalence of stunting remains as high as 30% in some settings.² The World Health Organization's Global Nutrition Targets for 2012 to 2025 aim to reduce the prevalence of stunting by 40% and the prevalence of wasting to less than 5%. Many countries in sub-Saharan Africa (SSA) are on track to reach these targets, but few are expected to achieve Sustainable Development Goal 2.2 to end malnutrition by 2030.³

Growth faltering is commonly attributed to prenatal, genetic and epigenetic factors as well as environmental exposures after birth including inadequate diet, unclean water and poor sanitation and hygiene (WASH), poor parental education, repeat acute episodes and chronic subclinical inflammation of the small intestine.⁴ Yet WASH and nutrition interventions have had a mixed impact on growth outcomes,⁵ while reductions in child mortality and diarrhoeal disease have not produced the expected fall in stunting.² Recent evidence from rural Gambia suggests that major and sustained improvements in living conditions, disease reduction, diet and healthcare may be needed to eliminate undernutrition.^{2,6} The causal pathways remain poorly understood, however, precluding effective intervention.

Here we explore the role of temperature in growth faltering in SSA.⁷ For thermoreostasis, humans have two responses to heat stress: (1) decreasing food intake to reduce metabolism and heat generation and (2) increasing heat loss, for example through increased sweating, a higher area-to-mass ratio and behavioural adaptations including reduced activity. In an earlier study, Wells hypothesised that these responses may contribute to growth faltering among children living in hotter climates *via* three mechanisms.⁷ First, decreasing food intake will reduce growth and enhance heat loss through an increased area-to-mass ratio. Second, prolonged heat exposure creates a selective pressure for reduced body size. Indeed, there is evidence that Bergmann's rule - that smaller organisms are found in warmer regions - may apply to modern humans where there is a difference between populations greater than 50 degrees of latitude and/or 30°C.⁸ Importantly, any influence on body size is likely to manifest as wasting (low weight-for-height), which increases area-to-mass ratio and cooling capacity, rather than stunting (low height-for-age), which has little effect on area-to-mass ratio.⁷ Third, heat stress incurs a high energetic cost, for example due to increased sweating. Together, these effects are more pronounced in young children who have a poorer heat tolerance than adults due to their lower sweat rate and blood volume, among other factors.

We assessed whether exposure to high temperatures in SSA is associated with child growth faltering. Ours is one of the first studies to explore a direct relationship between environmental temperature and early childhood growth outcomes. Our analysis is timely, given the predicted increase in global mean surface temperature by 0.3°C to 4.8°C by the end of this century, relative to the late 20th century,⁹ and the urgent need to understand the effects of anthropogenic climate change on health.

Methods

Data sources:

Growth outcomes in children aged ≤5 years: Data were extracted from the Demographic and Health Surveys (DHS) and Malaria Indicator Surveys (MIS).¹⁰ The DHS and MIS collect health and sociodemographic data using a two-stage random cluster sampling strategy, where clusters are randomly selected from census files and households are randomly selected in each cluster. We included all georeferenced DHS and MIS conducted in SSA and available online by December 2018, that collected data on anthropometric data and all prespecified covariables. Stunting was a height-for-age *z* score (HAZ) greater than two standard deviations below the reference median, wasting a weight-for-height *z* score (WHZ) <-2 and underweight a weight-for-age *z* score (WAZ) <-2.

Healthcare and household characteristics: For each child the following variables were extracted from DHS and MIS datasets: (1) age, (2) sex, (3) insecticide-treated net (ITN) use the night before the survey, (4) receipt of the third diphtheria-pertussis-tetanus (DPT-3) vaccination, (5) receipt of the first measles vaccination (measles-1), (6) any reported episode of diarrhoea in the two weeks before the survey, (7) improved or unimproved drinking water source categorised using World Health Organization Joint Monitoring Programme (WHO-JMP) criteria,¹¹ (8) improved or unimproved sanitation facility categorised using WHO-JMP criteria,¹¹ (9) education level of the household head, (10) urban or rural residence and (11) floor type (finished (e.g. parquet) *versus* unfinished or natural material (e.g. earth)).

Household wealth: Household wealth index scores were calculated for each survey using linear principal component analysis (PCA). We applied inclusion criteria of: (1) fewer than 10% missing values and (2) population frequency between 5% and 95% to the following assets: (a) car, (b) motorboat, (c) scooter, (d) cart, (e) bicycle, (f) television, (g) refrigerator, (h) radio, (i) watch, (j) mobile telephone, (k) landline telephone and (l) electrification of the household. To condense these twelve assets into a single dimensional index we tested isometric mapping, kernel principle component analysis, t-distributed stochastic neighbour embedding and linear PCA. We found minimal differences between algorithms, so used linear PCA because it is the most commonly used algorithm for wealth indices.¹²

Climatic and environmental variables: For each georeferenced survey cluster the following data were extracted: (1) synoptic mean monthly daytime land surface temperature (LST) from 2000 to 2016 (i.e. the average temperature for each month derived from a multi-year time-series),¹³ (2) synoptic mean monthly enhanced vegetation index (EVI) from 2000 to 2016, a measure of the proportion of photosynthetically active radiation absorbed by vegetation, which is correlated with vegetation density and active photosynthesis,¹³ (3) synoptic total monthly precipitation from 2000 to 2016,¹⁴ (4) night-time lights, a proxy for regional wealth and urbanicity¹⁵ and (5) accessibility to large cities in 2015.¹⁶

Data analysis: Logistic regression was used to estimate the odds of stunting, wasting, underweight and concurrent stunting with wasting at the level of the child, relative to synoptic mean monthly daytime LST from 2000 to 2016 for the survey cluster. Figure 1 illustrates that a LST of 30°C approximately translates into an air temperature of 27°C,¹⁷ although this relationship is variable and depends on the month. The analysis controlled for survey, age and sex of the child, ITN use, DPT-3 vaccination, measles-1 vaccination, reported diarrhoea in the past two weeks, type of drinking water source, type of sanitation facility, attendance of the household head at secondary education, urban or rural survey cluster, type of household floor material, household wealth, monthly mean EVI, mean total monthly precipitation, night-time lights and accessibility to large cities. Since growth outcomes vary with age¹⁸ we stratified the analysis by age group (<2 years *versus* 2-5 years old). To allow for a non-linear relationship between temperature and growth outcomes, LST was modelled as a categorical variable (<30°C, 30°C to <35°C, 35°C or greater). These cut-offs were chosen to give a similar number of children in each temperature category. Due to the hierarchical nature of the dataset in which children were sampled within households and clusters, we used confidence intervals that accounted for the highest level of clustering (i.e. survey cluster) and we included survey as a fixed effect in the model.¹⁹ Standard errors were estimated using Taylor linearization.

Results

Study population: Summary statistics are presented in Table S1. Data were extracted for 121 DHS, MIS and AIS surveys. Of these, 52 DHS surveys that measured growth outcomes and all prespecified covariables were included in the multivariable analysis. The included surveys were conducted from 2003 to 2016 in 29 countries. The total study population comprised 656,107 children aged 0-5 years, resident in 373,012 households. The median cluster size was 15 households (interquartile range (IQR) 11-18 households). The mean age of children was 2.5 years (95% confidence intervals (CI): 2.5-2.5 years) and 49.7% (325,919 of 656,096 children) were female. During 2000 to 2016 monthly mean LST in survey clusters ranged from a median of 26.1°C (IQR: 25.2°C to 28.5°C) in Gabon to 37.7°C (IQR: 36.1°C to 39.2°C) in Chad (Figure 2).

Association between temperature and growth outcomes in children:

Stunting: Height and age were recorded for 336,299 children in 52 surveys, of whom 102,213 (30.4%) were stunted. Stunting was more common among children aged 2-5 years (33.5%; 68,674 of 205,031 children) than children aged <2 years (25.6%; 33,539 of 131,268 children) ($p<0.0001$) and among males (31.9%; 53,950 of 169,265 children) than females (28.9%; 48,263 of 167,033 children) ($p<0.0001$). Stunting prevalence ranged from 15% (977 of 6,637 children) in the Senegal 2016 DHS to 49% (1,758 of 3,624 children) in the Burundi 2010 DHS (Table S1). In the unadjusted analysis, the odds of stunting were 17% higher among children living in survey clusters where monthly mean daytime LST exceeded 35°C, compared to less than 30°C (Odds Ratio (OR) 1.17, 95% confidence intervals (CI) 1.13-1.21, $p<0.0001$) (Table S2). Controlling for the variables stated in the methods section, the odds of stunting were 10% lower among children living in survey clusters where monthly mean daytime LST exceeded 35°C, compared to less than 30°C (OR 0.90, 95% CI 0.85-0.96, $p=0.00047$) (Table 1). The reduction in stunting associated with LST exceeding 35°C, compared to less than 30°C, was greater in children aged 2-5 years (OR 0.89, 95% CI 0.83-0.95, $p=0.00081$) than in children aged <2 years (OR 0.92, 95% CI 0.85-0.99, $p=0.034$).

Wasting: Weight and height were recorded for 335,835 children in 51 surveys, of whom 26,264 (7.8%) were wasted. Wasting was more common among children aged <2 years (10.3%; 13,351 of 130,054 children) than 2-5 years (6.3%; 12,913 of 205,781 children) ($p<0.0001$) and among males (8.3%; 14,038 of 169,013 children) than females (7.3%; 12,226 of 166,820 children) ($p<0.0001$). Wasting prevalence ranged from 2% (67 of 3,828 children) in the Rwanda 2015 DHS to 15% (3,897 of 26,463 children) in the Nigeria 2013 DHS. In the unadjusted analysis, the odds of wasting were 95% higher where monthly mean daytime LST exceeded 35°C, compared to less than 30°C (OR 1.95, 95% CI 1.85-2.05, $p<0.0001$) (Table 1). In the adjusted analysis, the odds of wasting were 27% higher where monthly mean daytime LST exceeded 35°C, compared to less than 30°C (OR 1.27, 95% CI 1.16-1.38, $p<0.0001$). The increase in wasting associated with LST exceeding 35°C was similar across age groups (age <2 years: OR 1.27, 95% CI 1.15-1.40, $p<0.0001$; age 2-5 years: OR 1.28, 95% CI 1.13-1.45, $p=0.0001$).

Underweight: Weight and age were recorded for 330,809 children in 51 surveys, of whom 75,019 (22.7%) were underweight. Underweight was more common among children aged 2-5 years (23.6%; 47,587 of 201,562 children) than <2 years (21.2%; 27,432 of 129,247 children) ($p<0.0001$) and among males (23.4%; 38,887 of 166,487 children) than females (22.0%; 36,132 of 164,321 children) ($p<0.0001$). Underweight prevalence ranged from 7% (203 of 2,784 children) in the Swaziland 2006 DHS to 37% (4,017 of 10,749 children) in the Chad 2014 DHS. In the unadjusted analysis, the odds of underweight were 64% higher where monthly mean daytime LST exceeded 35°C, compared to less

than 30°C (OR 1.64, 95% CI 1.57-1.70, $p<0.0001$) (Table 1). In the adjusted analysis, the odds of underweight were 9% higher among children living in survey clusters where monthly mean daytime LST exceeded 35°C, compared to less than 30°C (OR 1.09, 95% CI 1.02-1.16, $p=0.0073$). The increase in underweight associated with LST exceeding 35°C was slightly greater in children aged <2 years (OR 1.11, 95% CI 1.03-1.21, $p=0.011$) compared to children aged 2-5 years (OR: 1.07, 95% CI 1.00-1.16, $p=0.063$).

Concurrent stunting with wasting: Height, age and weight were recorded for 330,809 children in 51 surveys, of whom 6,982 (2.1%) were both stunted and wasted. Concurrent stunting with wasting was more common in children aged <2 years (2.5%; 3,185 of 129,247 children) than 2-5 years (1.9%; 3,797 of 201,562 children) ($p<0.0001$) and among males (2.4%; 4,039 of 166,487 children) than females (1.8%; 2,943 of 164,321 children) ($p<0.0001$). The prevalence of concurrent stunting with wasting ranged from 0.4% (27 of 6,142 children) in the Zimbabwe 2015 DHS to 5% (512 of 10,749 children) in the Chad 2014 DHS. In the unadjusted analysis, the odds of concurrent stunting with wasting were over two times higher where monthly mean daytime LST exceeded 35°C, compared to less than 30°C (OR 2.08, 95% CI 1.92-2.25, $p<0.0001$). In the adjusted analysis, the odds of concurrent stunting with wasting were 23% higher where monthly mean daytime LST exceeded 35°C, compared to less than 30°C (OR 1.23, 95% CI 1.07-1.41, $p=0.0037$). The increase in concurrent stunting and wasting associated with LST exceeding 35°C was greater in children aged 2-5 years (OR 1.29, 95% CI 1.06-1.57, $p=0.0099$) compared to children aged <2 years (OR 1.18, 95% CI 0.98-1.41, $p=0.073$).

Discussion

We tested the hypothesis that young African children exposed to high temperatures will experience growth faltering. By analysing data for children aged 0-5 years from 52 national surveys in SSA, we found that monthly mean daytime land surface temperatures (LST) exceeding 35°C were associated with a 27% increase in the odds of wasting, a 9% increase in the odds of underweight and a 23% increase in concurrent stunting with wasting, but a 10% reduction in stunting, compared to temperatures averaging less than 30°C between 2000 and 2016. Previous studies of a direct effect of temperature on child growth are scant. In a key study, Wells developed a model of the relationship between body size and heat production, showing that growth faltering can theoretically relieve heat stress in childhood and recommending empirical investigation of this hypothesis.⁷ Other studies support a role for environmental temperature in early child growth, such as birthweight.^{20,21} For example, Wells and Cole observed across 108 populations that a one unit increase in heat index was associated with a 3% decrease in birthweight.²⁰ To our knowledge, ours is the first empirical investigation of a direct relationship between temperature and early childhood growth outcomes.

High temperatures are hypothesised to contribute to growth faltering through three main mechanisms.⁷ First, wasting may be an adaptive response to high temperatures. Arguably it is harder to avoid heat stress in hot climates *via* behaviour change than in cooler climates, creating a greater reliance on physiological adaptations, particularly increased area-to-mass ratio.⁷ In the first three years of life, this pressure is exacerbated because the fatness of young children creates a low area-to-mass ratio and, compared to adults, young children have a lower sweat rate, greater blood volume per unit mass, higher metabolic rate per unit mass and higher metabolic cost of locomotion, making it harder to keep cool.²² In addition the heat stress experienced in hot climates may be exacerbated in some African communities if a baby is swaddled, the young child is carried on its mother's back (Figure S1) or the child sleeps in a metal-roofed house. In malnourished children energy expenditure may be higher still, because organ tissue (which has a higher metabolic rate than normal tissue) is proportionally larger than in healthy children.⁷ Second, linked to physiological adaptation, appetite may be reduced in higher temperatures.²³ If prolonged, lower food intake would contribute to growth faltering. Third, there is an energetic cost to keeping cool. Approximately 40-50% of total energy expenditure in mammals is used to maintain a constant core temperature and a 1°C increase in body temperature is associated with a 10–13% increase in metabolic rate.²⁴ Children experiencing long-term heat stress may therefore allocate less energy to growth.

Increased temperatures were associated with a greater risk of wasting and underweight but a decrease in stunting. While future studies are needed to replicate this finding, there are several potential biological explanations. First, ambient temperature is known to modulate bone elongation in mammals, with limbs of animals raised in warmer ambient temperatures significantly and permanently longer than those of siblings housed at cooler temperatures.²⁵ Thus, human limb length may increase with heat exposure. Second, if wasting is protective in high temperatures,⁷ stunted children may have a higher mortality rate than wasted children under heat stress. Wells' model of temperature and body size suggests that stunting and wasting both affect surface area and energy expenditure, but stunting causes little increase in area-to-mass ratio in children aged 0-2 years.⁷ In contrast, wasting increases area-to-mass ratio by at least 15% in young children, promoting cooling capacity in early infancy. We found stunted children to be older than wasted children and the reduction in stunting associated with higher temperatures to be most pronounced among children aged 2-5 years. This is consistent with a decline in prevalence of stunted children in higher temperatures due to increased mortality, although research is needed to understand this further. There may be other, unknown, temperature-related drivers making wasting a more likely outcome of undernutrition than stunting as temperatures rise.

We hypothesise that a decline in stunting associated with increased temperatures may also be linked to genetic factors. Only 2% of our study population was both stunted and wasted, similar to a pooled

prevalence of 3% in the same age group from a meta-analysis of 84 countries.²⁶ This partly reflects the high mortality rate in children affected by both,²⁷ but also illustrates how stunting and wasting largely affect different children. Indeed, a high prevalence of stunting can be observed in populations where wasting is uncommon.²⁸ Human height is approximately 80% genetically determined by at least 600 genetic variants that are not yet fully understood,²⁹ with Africans having the highest levels of within-population genetic diversity worldwide. It is possible that height in African populations is influenced by unknown epigenetic factors that interact with environmental temperature. Studies of the prevalence of stunting in relation to both ethnicity and environment in SSA may be insightful.

We found that the relationship between temperature and growth outcomes varied with children's age, with the association between high temperature and growth faltering greater among children aged 2-5 years than 0-2 years for stunting and concurrent stunting with wasting and the same association smaller among children aged 2-5 years than 0-2 years for underweight. A previous study demonstrated systematically larger estimates of association with risk factors for stunting in children aged 2-5 years than <2 years, but systematically smaller effects in the older age group for wasting.¹⁸ This may be because wasting rates are generally highest in children aged less than two years, but stunting can take longer to manifest and is more prevalent after two years.¹⁸ Here we observed a similar pattern. Our analysis demonstrates the importance of age disaggregation in observational studies of child growth.

Previous studies investigating the causes of stunting, wasting and underweight have focused mainly on nutrition, socioeconomic factors, exposure to infection and maternal health.⁴ Yet the persistence of growth faltering in SSA despite the scale-up of nutrition and hygiene-based interventions suggests additional causes.² The few studies to have explored the role of climate have focused on the effect of environmental temperature on food security,^{30,31} rather than a direct biological effect, as we have done here. Further research is needed to validate and understand our findings, but a direct, causal link between temperature and growth faltering would have major implications for public health. Mean annual temperatures are expected to rise by 2°C across Africa by the end of this century, relative to the late 20th century, with some scenarios showing rises of between 3°C and 6°C for the same period.⁹ Estimates of future deaths attributable to climate change as well as public health strategies to mitigate against its effects may therefore need to consider growth faltering. Importantly, if wasting is an adaptive and arguably protective response to high temperatures, it may be helpful to counteract this effect by keeping children cool while ensuring adequate nutrition. While research would be needed to identify appropriate interventions, one possible approach could be the promotion of cooler housing in hotter parts of SSA. Rather than air conditioning, this can be achieved with buildings with low thermal mass and good ventilation.³²

We observed an association between environmental temperature and child growth, but further research is needed to understand the extent to which this is mediated by food security and poverty, rather than a direct biological effect. Hotter climates are generally associated with greater levels of poverty which is related to child growth. For example, Chad was the hottest country included in our analysis, but ranks near the lowest of the global human development index.³³ Despite controlling for local differences in wealth using a household-level wealth index, education level of the household head, urban-rural status and night-time lights, residual confounding is possible. Higher temperatures can also be associated with lower crop yields, affecting nutrition, and we attempted to control for this using EVI and precipitation. On the other hand, local climate is one of many factors influencing food security, which is also determined by food distribution, exchange and affordability, the resources available to prepare food safely, and the stability of such factors over time.³⁴ Incorporating survey as a fixed effect in our model helped to account for national-level variation in such factors.

Our study has several limitations. First, our measure of temperature was based on synoptic means from 2000 to 2016 and is therefore an imprecise measure of climate conditions experienced by children of different ages and surveyed in different years. Nonetheless, child growth is a long-term process that would be expected to respond more slowly to environmental conditions than other health outcomes, such as vector-borne disease. Similarly, we used synoptic means for precipitation and EVI and static estimates for night-time lights and accessibility. Second, LST does not directly translate into ambient temperatures, although it is the most precise metric of temperature available from remotely sensed data.¹⁷ Third, the OR, while a valid measure in its own right, may not be taken as approximation of the risk ratio when the outcome of interest is common (>10%). Fourth, as discussed, residual confounding by social and environmental factors is possible. Last, the causes of growth faltering are complex and our analysis is only a preliminary exploration of the role of temperature. Cross sectional data, like all observational data, cannot definitively determine causality. However, since it is not feasible to randomise children to high or low temperatures, it is the only method available to investigate this question. Further studies are needed to confirm our findings, such as the observed decrease in stunting at higher temperatures. Research is also needed to understand causal pathways, including whether the persistence of growth faltering represents an adaption to hot climates, and to understand the relationship between heat exposure and growth over the human life course. While we did not adjust for birthweight in our model, high environmental temperatures have previously been shown to be associated with lower birthweight^{20,21} and shorter gestational length.³⁵ Overall, we aim to highlight the potential role of environmental temperature in the growth of African children and to provide a stimulus for future research and discussion of this topic.

In conclusion, children aged 0-5 years living in areas of higher temperatures in SSA are more likely to be wasted and underweight but less likely to be stunted. Future studies should evaluate the

relationship between heat exposure and growth outcomes in children and elucidate causal mechanisms. Any direct effect of temperature on early childhood growth would need to be considered in light of the likely increases in mean temperature that Africans will experience this century, caused by climate change.

Author contributions

Conceptualization: FCS, SWL; data curation: LST, SB, HHG, DW, methodology: LST, JB, DW, SWL; formal analysis: LST, JB; writing – original draft: LST, FCS, SWL; writing – review & editing: LST, JB, SB, HHG, DW, FCS, SWL.

Declaration of interests

The authors have declared that there are no conflicts of interest.

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Data availability

All health data used in this analysis are available to download free of charge by registered users from the DHS Program. Registration is available at <https://dhsprogram.com/data/new-user-registration.cfm> and data may be downloaded at https://dhsprogram.com/data/dataset_admin/download-manager.cfm. Full dataset access instructions are available at <https://dhsprogram.com/data/Using-Datasets-for-Analysis.cfm>. Remotely sensed data are available to download from the cited sources.

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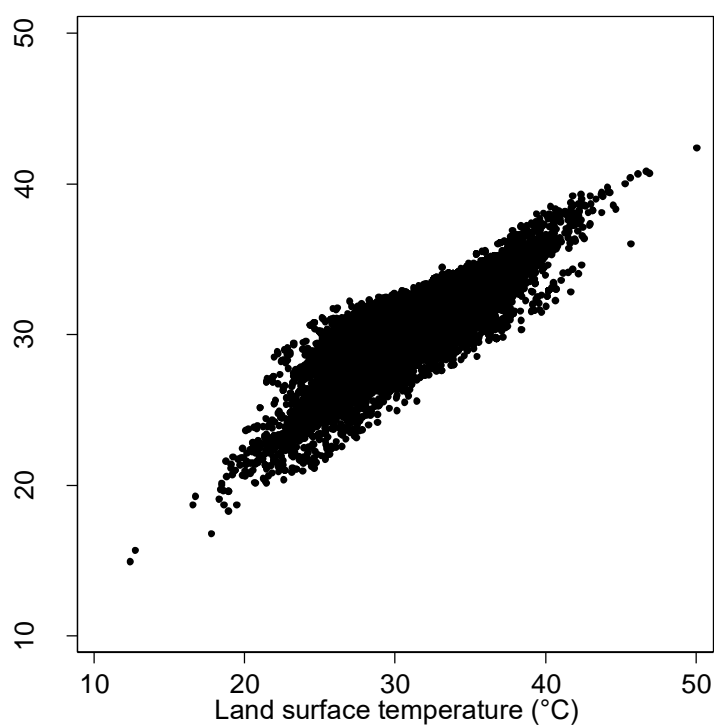


Figure 1. Monthly mean daytime air temperature *versus* monthly mean daytime land surface temperature for 25,089 georeferenced clusters in 52 surveys, 2000-2016. Air temperature was determined from land surface temperature using a standard conversion.¹⁷

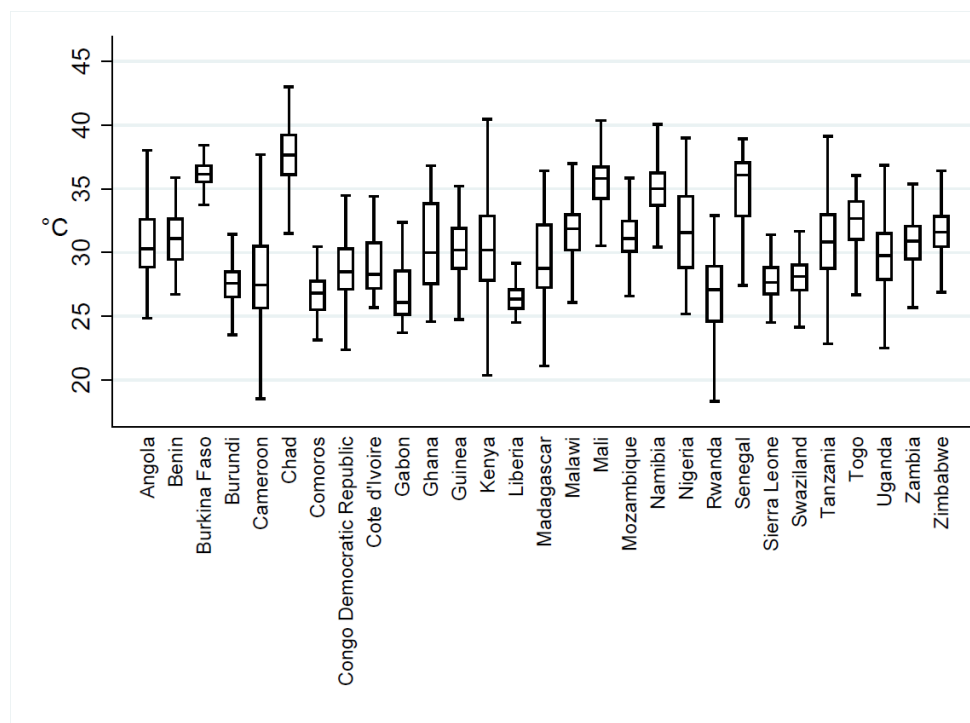


Figure 2. Monthly mean daytime land surface temperature for the 29 countries included in the analysis, 2000-2016 (median, interquartile range and range). Outside values are not shown.

Table 1. Association between land surface temperature and growth outcomes in children aged 0-5 years in sub-Saharan Africa

Land surface temperature ^a	Stunting			Wasting			Underweight			Stunting and wasting		
	Prevalence, % (N)	OR ^b (95% CI)	p	Prevalence, % (N)	OR ^b (95% CI)	p	Prevalence, % (N)	OR ^b (95% CI)	p	Prevalence, % (N)	OR ^b (95% CI)	p
<i>All children</i>												
<30°C	30.7 (96,687)	1		5.9 (94,587)	1		19.4 (93,957)	1		1.4 (93,957)	1	
30°C to 34°C	30.2 (106,552)	0.98 (0.94, 1.01)	0.0009	7.9 (106,006)	1.05 (0.99, 1.11)	<0.0001	21.8 (104,995)	1.02 (0.98, 1.06)	0.018	2.0 (104,995)	1.17 (1.06, 1.29)	0.0058
≥35°C	29.6 (66,668)	0.90 (0.85, 0.96)		12.5 (66,928)	1.27 (1.16, 1.38)		30.3 (66,343)	1.09 (1.02, 1.16)		3.6 (66,343)	1.23 (1.07-1.41)	
<i>Children aged <2 years</i>												
<30°C	25.8 (42,442)	1		7.9 (41,589)	1		18.5 (41,414)	1		1.7 (41,414)	1	
30°C to 34°C	25.9 (46,579)	0.98 (0.93, 1.03)	0.080	10.0 (46,197)	1.11 (1.04, 1.19)	<0.0001	20.5 (45,940)	1.07 (1.01, 1.13)	0.024	2.3 (45,940)	1.13 (0.99, 1.28)	0.15
≥35°C	24.0 (28,031)	0.92 (0.85, 0.99)		14.6 (27,986)	1.27 (1.15, 1.40)		26.7 (27,889)	1.11 (1.03, 1.21)		3.9 (27,889)	1.18 (0.98, 1.41)	
<i>Children aged 2-5 years</i>												
<30°C	34.5 (54,245)	1		4.4 (52,998)	1		20.2 (52,543)	1		1.2 (52,543)	1	
30°C to 34°C	33.5 (59,973)	0.98 (0.94, 1.02)	0.0013	6.2 (59,809)	1.00 (0.92, 1.09)	<0.0001	22.8 (59,055)	0.99 (0.94, 1.04)	0.018	1.9 (59,055)	1.22 (1.06, 1.41)	0.015
≥35°C	33.7 (38,637)	0.89 (0.83, 0.95)		11.0 (38,942)	1.28 (1.13, 1.45)		33.0 (38,454)	1.07 (1.00, 1.16)		3.4 (38,454)	1.29 (1.06, 1.57)	

^a Monthly mean daytime land surface temperature, calculated from synoptic monthly means from 2000 to 2016

^b Adjusted for survey, age and sex of the child, type of drinking water source, type of sanitation facility, DPT-3 immunisation, measles-1 immunisation, reported diarrhoea in the past two weeks, type of household floor material, ITN use, attendance of household heads at secondary education, urban or rural survey cluster, household wealth, mean monthly EVI, mean monthly precipitation, urbanicity, night-time lights and accessibility to large cities.

OR: Odds Ratio; CI: confidence interval